North Dakota EMS Advisory Committee
January 15, 2004
Heritage Center
Bismarck, ND

Members Present: Tim Meyer, Darleen Bartz, Larry Weber, Tim Luithle MD, Cheryl Flick, Neil Frame, Rod Gilmore, Sen. Jerry Klein, Dan Ehlen, Donna Hegle, Dave Peske, Rep. Todd Porter, Mark Weber, Kent Hoerhauf, Carol Eisenbeis, Nancy Capes, Raphael Ocejo MD, Janelle Pepple, Donna Pretzer, Ben Roller MD, Alan Aarhus,

Introductions

Meyer: Discussed committee reimbursement for travel.

Larry Weber gave a presentation on the history of the state EMS office, EMS certification levels, and training courses authorized by the Department of Health.

- Rod Gilmore commented on data collection from trauma centers and how that effects American College of Surgeons trauma center designations.
- Dr. Ocejo commented on the shortcomings of data collection for pediatric patients. Not all peds trauma will be hospital admits or captured in the trauma registry database.
- Dr. Hoerhauf explained the definitions of major trauma patients and how the trauma registry does not capture minor trauma.
- Dr. Ocejo states that the blues capture all that data but have no staffing to do analysis.
- Rod Gilmore discussed the collection of data through the billing systems.
- Meyer explained the DREAMS project and how every patient contact will be captured by the Department of Health through surveillance software.

Mark Weber gave a presentation on the status of EMS systems and providers in the state of ND. An overview of where EMS has been, where we are, and where EMS needs to go.

- Mark Weber discussed the problem of dwindling volunteer pool and how some services have gone to paying staff to cover their shifts.
- Sen Klein asked Mark how much training to become an EMT. Mark answered 110 hrs. Klein then asked if there was a correlation between the time when EMT training hours increased to when the volunteer numbers decreased. Mark Weber said there was not a correlation.
- Larry Weber commented that there are far more EMTs than there are Drivers in EMS (no training involved).
- Klein discussed the training requirements and says that he hears from some volunteer EMS providers that there is too much time involved to volunteer.

- Dr. Hoerhauf discussed that services need strong leadership and a community champion to provide morale and leadership to create a strong well staffed organization. And the lack of that is often the key reason the an EMS organization has declining membership.
- Alan Aarhus discussed how community champions are usually overused in the community for other civic duties and they too become burned out.
- Nancy Capes described Red River Rescue's model of training of one weeknight a month on a continual basis. So over time they have completed all of their training requirements without having to give up several weekends every year.
- Dr. Roller discussed how many years ago there were many young volunteers available to participate where now the general population has decreased. He feels that perhaps an ambulance service should be allowed to not be available 24/7 so that more people would be able to participate and the ambulance service would be in compliance with state law.
- Mark Weber commented that we have mechanisms now that allow that to a degree and ambulance services should be looking for ways to build EMS systems rather that preserving stand alone ambulance services.

Meyer than explained the duties and responsibilities of the committee.

Meyer opened discussion of the administrative rules that apply to air ambulance. He explained the process for the rules process and discussed how the air ambulance rules were held over by the Administrative Rules Committee.

First rule 33-11-04-05 availability of air ambulance.

Discussion:

- Meyer explained that the rule as written would not allow a charter operator to do air ambulance on the side. There was concern by the legislators that this would inhibit business opportunities in ND. Meyer explained that the FAA had made regulations for air ambulance years back that had drastically limited charter operators from doing this.
- Dr. Roller explained that over the years when dealing with air ambulance charter operators wanted to do air ambulance but their equipment list was very meek and did not meet quality standards. And a charter operator that had a dedicated aircraft and personnel had a better quality operation.
- Dan Ehlen agrees that the rule as written would limit the small operator but the rules are in effect to protect the patient not the businessman. He would like to see critical care air ambulance be added to the administrative rules.
- Rep Porter states that there are many things that limit air ambulance availability and has concerns that it was not his intentions to put functioning community air ambulances out of business by requiring them

to be available for air ambulance operations 24/7. This rule restricts the functioning of air ambulance in rural ND.

- Donna Hegle agrees with Dan Ehlen in that when someone calls themselves an air ambulance the public needs to know that what they are getting is an air ambulance and who the personnel are that will be taking care of the patient and what kind of equipment and supplies will they have available so that a service wants to continue with this as a part time business that they would be licensed as a BLS service so that a consumer would know what kind of service they would be getting.
- Meyer asked the group if they are saying that a BLS ambulance would not have to be available 24/7.
- Ehlen explained that a part time operator would have an advantage over a full time operator because reimbursement is exactly the same for BLS and ALS whether the aircraft is available 24/7 or not.
- Dr. Luithle feels it is a safety issue and probably would not use BLS to transport.
- Bartz explained that Medicaid would pay to transport patients that require no care or no care givers like transplant recipients.
- Dr. Ocejo states that ALS air ambulance service must be available 24/7.
- Dr. Hoerhauf believes that 24/7 requirement will never exist because often the air ambulances are unavailable on other missions. As long as the quality of patient care is maintained a part time operator should be able to do air ambulance on the side.
- Sen Klein asked what are we doing now since we had never had any rules for air ambulance. Feels that we had something that seemed to be working but now during the rules process had maybe gone too far and limiting the quality of care in the rural areas. That's why the Administrative Rules committee made the decision to hold over the air ambulance rules.
- Larry Weber: I wrote the rules by looking at other states that license air ambulances and tried to go with the middle ground with regulations.
- Dan Ehlen: The national accrediting body called the Commission on Accreditation of Medical Transport Systems (CAMTS) has a third level of air ambulance called critical care transport.
- Meyer: Out of the 50 states all but 8 state have air ambulance rules.
- Larry Weber: All of the other states that he researched had a 24/7 requirement except for weather. We have always assumed even in ground ambulance that maintenance is a given as a reason to not be available.
- Ehlen: Believes that the trend is for states to adopt the CAMTS standards but says that they are very stringent and probably not appropriate for western ND.
- Donna Hegle: is concerned that without rules a provider would not know what he or she would be getting when calling for an air ambulance. Would you get a nurse or only a paramedic or only an emt? You would know that you would be getting an RN and a Paramedic when you call Minot because we are critical care and that's how we staff.

- Porter: Going back to the rule, a charter operator could be untruthful about the weather when in fact the aircraft is chartered out so the rule in not enforceable. Do you want a set of state laws that don't mean anything or do you want laws that focus on the patient care aspect.
- Meyer: other parts of the air ambulance rules have the equipment and personnel standards.
- Porter: 24/7 means nothing. The meat of the statute is the equipment and training standards. If an operator is continually not available sooner or later people will just quit calling them. I don't think it's enforceable and would like to see the 24/7 requirement eliminated.
- Luithle: When I call an air ambulance I might know the difference between BLS, ALS, and critical care but I don't think that all the providers in my service area are going to know the difference between those levels.
- Roller: leave out the 24hr requirement but the service should be delineated by level 1 (ALS), level 2 (BLS), or 3 (air medical taxi) no care required.
- Porter: I don't think that level 3 needs to be described in rule. They would not be able to bill medical insurance for that service anyway.
- Roller: I didn't understand that.
- Bartz: The department of Health would not have the authority to license a non medical entity.
- Ehlen: I would like to have the 24/7 rule stay.
- Roller: EMTALA rules leaves the responsibility of ensuring the patient care while enroute to the receiving physician. And most of those are ALS transports. On the other hand there are patients that don't need ALS or immediate transfer and that would be a BLS transport. BLS transport would not have to be available 24/7.
- Meyer: I don't want to go back to the administrative rules committee with nothing. They wanted me to get some compromise and agreement here. What I'm hearing at the meeting is that perhaps that BLS would not have to be available 24/7 and also to add that another reason for non-availability as other FAA requirements.
- Porter: I think that will address some of the concerns of rural ND.
- Klein: before these rules that pass many legislators will ask a person that is in the industry to see if the rules are reasonable so I ask Porter if he's onboard? I hope he speaks up now so we can make this work for everyone.
- Porter: I think this is acceptable, it addresses the concerns of rural ND. The services that can't have a full time dedicated airplane can still provide those services to their community. I think that kind of a balance between ALS and BLS is going to help rural ND.

Motion:

- Roller: Moves to change the rules to state that BLS does not need to meet the 24/7 requirement and to change and add the exception of FAA requirements for availability. ALS must be 24/7 availability.

- Ehlen: Seconds the motion.

Motion unanimously passes by voice vote.

33-11-04-06 Number of Personnel required.

Discussion:

- Meyer: describes the rule that ALS requires 2 providers, one of which must be at least a paramedic. Describes the controversy that some legislators feel that is burdensome to rural provider.
- Ehlen: Many times when we go to get a patient we don't always know the condition of the patient before we get there. We don't get a good enough idea of the condition of the patient from the referring physician.
- Luithle: We have had times that we have called for an air ambulance for one patient and found that we needed the service for another more critical patient. Had we only had one person for the initial dispatch, it would have not been appropriate for the second patient that was actually transported. I think that two persons is appropriate in rule.
- Roller: On the other hand you may have a patient that needs transport, that only has an IV running and needs IV Morphine. That person would not need two persons providing care.
- Ehlen: We never send an aircraft with only one provider.
- Porter: Since I raised the concerns at the interim committee the things I was looking for as a sponsoring legislator is that the state of ND, when they set up the rules, they are setting them up as the minimum, not the maximum. If you are operating your air ambulance and you say that you have to have 2 people on every flight within your system and you market yourself as such, then that is your system. Within ALS transports there are situations when you are doing inter-facility transports of stable patients that may have an IV and a monitor and they only need one care provider in the back and maybe a family member wants to ride with. I don't think that this is setting up the minimums, I think that what we've set up is the maximum. When I look at these rules I want to look at them as this was set up as the minimums. Would I send one paramedic on a critical flight from Williston to Bismarck on a head injury? No I'd send a paramedic and a nurse because our system is set up to do that. But would I send a two people for a stable transfer from telemetry down to Abbott NW where the cardiologist says I need just one paramedic? No I send one paramedic, that's the flexibility within the system. But I think that it's incumbent on the providers to know which part of the business you are dealing with. When you are dealing with emergency situations as have been described yea, you'd send two people. When you are dealing with non emergency ALS type transportation, you don't always necessarily need two people on particular airplane. It's up to the sending physician really is what it comes down to, and that's who we're dealing that situation who we talk to when

we say hey doc, do we need to send two medics , do we need to send a nurse, who do we need to send? No, your fine with one person. That is that physician's call. If I was going to be really, truly concerned with something happening in the air, I would be more concerned with the pilot the passing out and not having anybody else in the plane to fly the plane more so than I was about something happening to the patient than not being able to take care of it as a single care provider while enroute.

- Roller: How do you think it should be worded?
- Porter: One.
- Hegle: The national standards require two, including BLS. On BLS is says that only if there's no other option available in the region should you transport any patient with one. I don't think that as a state we want to say to everybody else well we don't need be politically accepted. Air medical standards, these are not just for the US these are for the world. This is the accepted standard. I don't have a problem with them doing it on the BLS, but I do have a problem with ALS, it assumes that your patients have a higher risk and having been a nurse for many years I've seen many stable patients code right in front of me unexpectedly.
- Meyer: The rule describes BLS as a one person standard. What we allowed in ground ambulance for years is that if you're licensed at the BLS level and you have ALS providers, equipment, training, and protocol you can do ALS calls. Thinking through this, and Todd (Porter) raised that point, we intended to let BLS licensed air ambulance to do those lower level ALS calls with a paramedic, in the spirit that we've used that interpretation for ground ambulance.
- Larry Weber: You say that you think it should be two on every one, like the national standards?
- Hegle: For ALS, if you're on an ALS transport.
- Larry Weber: Every time we've ever written any rules, whether they're written bad or not, we've always gone with the minimum standard and certainly any air ambulance service can go with whatever they want, and maybe some of them follow CAMTS. If they want to follow those, they certainly can.
- Luithle: Todd, in that transfer that you're describing, if the cardiologist here in Bismarck writes an order for, changes his order somewhat to say BLS air ambulance service transport. Is that an education issue from the provider and the doctor standpoint that then according to that rule, BLS air ambulance service the minimum is one primary care provider? So if you ask the doctor and say can we take it with one?
- Porter: It wouldn't work that way because the care required enroute be it patients on an EKG monitor, they came off a telemetry floor, and physician still wants him monitored so they would have to be an advanced level, that wouldn't fit the basic level.
- Meyer: We do allow that with ground BLS ambulance now. That's how Watford City for instance can take a paramedic or a nurse and a monitor

and they flex up to do these ALS calls. And it works well, in the rural world.

- Larry Weber: There are a number of BLS ambulance services that have one or two paramedics on staff and they are allowed, as long as their licensed by their physicians they are allowed to practice to that level.
- Ehlen: It happens quite often in Fargo is that when we are doing a transport from Fargo to Rochester, after we've dropped the patient off, on the way back, we are available and a lot of times we'll stop in Bemidji or something and pick up a patient who will require two providers and if we go with only one, we can't stop and pick that patient up so you've availability is not there.
- Porter: But nothing's telling you in Fargo to change the way that you're doing business. You're doing business that way, you choose to do business that way.
- Ehlen: Yes, if you want to do it business wise it makes sense to decrease the number of providers you have to pay, you're going to get reimbursed at the same rate and rake in more money with less people you put in the aircraft.
- Hoerhauf: When we're talking about advanced life support, we're at a certain level of care. I think that was a bad example, not to pick on you (to Porter) but you know that's an unstable patient that has an arrhythmia that could go sour on you and you can't resuscitate a patient with one individual. You're going to have to have two people to maintain airway and do chest compressions and push meds. I just think that if you're billing an advanced life support and I'm saying ALS unit, I'm expecting two people. And this grey hair has seen some things coming down the pike I remember getting the (air) ambulance out of Bismarck and an Anesthesiologist would be there along with a highly trained nurse and they'd assess the patient and it was a very high level of care. Now when I call for ALS I get a Nurse or a paramedic trained in that and it makes me a little uneasy because I'm used to that anesthesiologist that came out. These people could care less if I give them a history or not. I mean I'm just in their way they're just going to pack them up and get out of the way. If I just shut up and stay out of their way they're happier. If I tell them patient history and the like and they just look at me kind of funny and I tell them about some of the nuances of care and some of the things that they're going to have to watch out for. I mean they really don't care about that, or the impression I get is that they don't want to be bothered. So I have seen different levels of care and when I read this, I think that when you are saying minimum of two, I would say 100%. I would feel uncomfortable asking for ALS air service and if it's going to be a conversation between the hospital that's going to be receiving making decisions who's going to come out, as you said, you can't really appreciate what's going on until you lay hands on the patient. I really feel strongly that you have to have a minimum of two on ALS. BLS that defines a certain level of care. ALS says you have to have two people because things can go sour, it's hard to

resuscitate in air, you have to be prepared for the worse case scenario. I think you have to have two.

- Roller: A compromise might be in situation like this it's almost going to be a inter-hospital transport between two hospitals. Therefore it could be stated that for an ALS air ambulance service the minimum is one, but this is to be determined by both physicians (transferring and receiving).
- Hoerhauf: I think I'd feel a lot better knowing who's coming out.
- Roller: If you had any concerns, boom say two. That would take care of that issue. Because the patient that is the ND consumer is the one that is going to potentially be the one that's not going to get the appropriate service. Getting billed more or there's two people on board as opposed to one, unless you're saying that no it doesn't make and difference in billing, it's ALS period it's going to be the same thing.
- Meyer: I believe, correct me if I'm wrong, there is just air ambulance (billing). They break it out for helicopter or fixed wing.
- Hegle: So my reimbursement is better as far as my bottom line goes if I only send one person.
- Ehlen: We are not regulating business with these rules just patient care.
- Hegle: We should be looking out for what is safer for the patient. If the patient meets the criteria for ALS we should keep it two.
- Roller: I just think that the physicians on either end could make that decision and it has to be unanimous.
- Luithle: The point has been brought up that if I ask somebody to come up from Bismarck and there is only one provider in that ambulance, does that decrease the level of care in transport to the next facility?
- Roller: You would only need to have one provider.
- Luithle: I think we need to address if we are going to have a compromise here if I feel I'm needing a level than I could order it. If they feel on their end that they need a certain level than they could order it.
- Roller: That's exactly what I'm saying.
- Mark Weber: Couldn't you have two different levels, couldn't you have a non emergency transport and an emergency transport? And a non emergency transport, Like Todd said, and there are some patients that might need just a little pain meds that require an advanced provider and that's all they need.

Tape change.

Motion:

Roller moved to have the minimum ALS default to two personnel except when the transferring and receiving physician agree and authorize and ALS air ambulance service to transport a patient with only one care provider.

- Porter: So I guess I see it that even though the wording is an important compromise I see it as setting the standards more than what the minimum is rather than allowing the marketplace in allowing the providers to make sure that they have arrangements with their referring physicians that their dealing with. I don't think that we are supposed to be at a state level

setting up those operational standards, we are supposed to set the minimum in place and let the marketplace go.

- Meyer: I think that we are trying to protect the public that when those instances occur that they don't know the condition of the patient or that's an unknown where not accurately reported.
- Roller: I don't think this is a marketplace issue as well, it is a quality of care issue. And the quality of care if it's an unknown that error should be made on the side of protecting the patient, which is two people. On the other hand, if the patient's condition is known and can be decreased as far as level of care safely then the decision can be made. And I think that is the proposal in front of now is administer two then.
- Meyer: I guess I have another question, if this motion goes through and we write this in administrative rule is that something that will be legislated out in our next session? (to Porter) Are you taking issue with it? I don't want to waste everyone's time.
- Ehlen: We might as well fix it now.
- Meyer: Right.
- Meyer: I'm totally on board with you that ND is nice because we don't have a million rules. But it's my job to protect the public.
- Porter: I guess my personal look at it is that we should be looking at setting minimums, not maximums. The marketplace and the operators should dictate how they operate their business.
- Larry Weber: A minimum for you is just one right?
- Porter: I look at the minimum for the definition of ALS is just one. How many times has that happened for us flying patients? Probably in 10% of our flights.
- Larry Weber: I was just wanting to make sure, I was getting confused.
- Ehlen: I'm getting confused too. We are talking the minimum of two, not the maximum of two.
- Bartz: When we are looking at the ALS for ground ambulance, there are allowing one provider, but we are also requiring that the driver be at least an ECT or its equivalent. So that if you would wind up in an emergency situation you would actually have two providers available. And with airplane, the pilot is out of the picture. So we would be requiring less that is required by ground.
- Ocejo: I think that the safest rule is then put it, you can always go down but I know you're saying it's the minimum, but the minimum safest is two. If you know the state of the patient you can always lower it down. But I think that way you don't have surprises of all of a sudden finding yourself with an advanced life support air ambulance that arrives only with one when you actually needed two, or expected two. I think from the point of view of the safety for the patient the safest is to have two, you can always lower it down with the discussion among the physicians. That's my point of view.
- Meyer: That's the motion on the floor right now.
- Meyer: Is there a second?

- Luithle: Second.
- Meyer: Second by Dr. Luithle. Is there any discussion?
- Larry Weber: Is that the same as just saying, making the differentiation between BLS and ALS call? Isn't it already been worked or are you talking about dealing with possible critical patient?
- Roller: The thing of it is that ground ALS implies that you do have somebody else in the back of the rig providing basic life support.
- Larry Weber: I apologize and back off based on licensing the two types of services.
- Meyer: ok, is there any other discussion?
- Klein: In any situation that's were sending an ALS, wouldn't the docs automatically, are we legislating common sense here?
- Roller: No.
- Klein: (to Roller) Isn't your job to say , send those two guys out. And in a different case when he's making these transfers to Abbott Northwestern you're having a different discussion it would seem like, not in the same type of stress related.
- Roller: It's not common sense because, if you're talking to the physician on either end so we're talking maybe a small town doc you ask "how many personnel do you want on board?" (answer) "What do they usually do?" "Well, the minimum is one" he'll just say "well, go ahead" because they don't know. Doc's don't know….
- Klein: Up until Rep. Porter finally said we have to regulate air ambulance what did you guys say?
- Roller: There was no law.
- Klein: What was the discussion? I mean should we have one?
- Hoerhauf: I tell you, I've never had anybody less than two and a lot of times three arrive in Hettinger. I've never ever had one individual show up in advanced life support.
- Klein: I guess that's where I'm going.
- Ehlen: But it does happen, hasn't that happened in Grand Forks?
- Capes: It has happened with some services, not from North Dakota, scary.
- Roller: Why not put in the default as two, and if you want to override that you can for that 10%. It's going to a physician's order, the physician to consciously think, ok now we're going to go down to the one.
- Hegle: That's what it needs to be. That physician needs to really look and say "ok you're going to alone with this patient, are really going to be ok?"
- Roller: As opposed if you've got an operator that wants to cut costs and he wants to make a little bit more money, then you're going to say well going to really clean up whatever we can possibly go by with one. Oops, they get there, and they're not in trouble because the minimum is one.
- Ehlen: And I don't see a problem with it if Ben (Roller) has a patient he needs taken care of, and he knows he's taken care of, just as long as that's what he wants. It's not a problem.

- Meyer: Any other discussion? Any other discussion? Any other discussion? All those in favor say Aye.
- Meyer: Opposed same sign. Hearing none motion carries.

Motion unanimously carries by voice vote.

- Meyer: ok, a couple more quick administrative rules.

Dr. Roller leaves meeting.

- Meyer: here's a rule that refers to ground ambulance that "all equipment must be stowed in cabinets and securely fastened". I guess we took the common sense approach to that to mean that when you had to use the equipment it didn't have to be stowed. However there are times when like when using the cardiac monitor that it can be stowed and it is big and heavy piece of equipment that could be a hazard for personnel. Is there any discussion?
- (unknown person): was there some controversy?
- Meyer: Todd had a concern.
- Bartz: Todd, can you tell us your concern.
- Porter: I guess when you look at the blanket statement again where it says all equipment must be stowed in cabinets or securely fastened, it doesn't leave any room for equipment being used at the time while on a call and transportation to hospital.
- Meyer: If we just added to "when not in use"
- Porter: Perfect.
- Larry Weber: Again Todd, that was kind of a given, it was one of those things that we know is out there. Although there are some things coming down that talk about having stowed all the time just because of a number of people are being injured.
- Meyer: if that comes up, we can address that at another time.
- Porter: I can certainly understand that. I guess I can't understand driving down the road and needing something out of the drug box and having it open on the bench seat and getting into an accident and being sued because I broke a state law. Because the way this is written I would be braking state law. But then I would have to pull over every time I needed something out of the drug box in order to get it out.
- Larry Weber: It was a given, I just assumed that based on my seventeen years experience knowing.
- Ehlen: I'd like to make a motion as stated.
- Meyer: The motion is on the floor to add "when not in use". Is there a second?
- Frame: Second.
- Meyer: Is there any discussion? Any discussion? Any discussion? All those in favor say Aye. Opposed same sign. Motion carries.

Motion unanimously carries by voice vote.

- Meyer: The next administrative rule is a scope enhancement for Automated External Defibrillator. I don't know when this rule was put in place but I imagine it was some years past before AEDs were as common as they are now. It's under training, testing, and certification.
- Flick: I have a question when you require CPR now for EMT, or paramedic or other level is it the Healthcare Provider because they're automatically trained in AED?
- Meyer: Yes
- Flick: OK.
- Meyer: In CPR training now for health care providers it includes AED training. So what we have in rule is a redundancy that would require somebody to take CPR and then take another class just to run the AED. So theoretically an ambulance could show up and a person may have not taken that enhanced skill module, maybe on the ambulance crew, and cannot run the AED, but a bystander can operate it. Someone standing on the street corner can run the AED as a public access defibrillation. It doesn't make sense to me. I talked to John Walstad who is the administrative rules counsel and he said to rescind rules that were outdated the process is much shorter. We don't have to go to public comment. In our case, we just have to have it approved by the State Health Council and taken to the Administrative Rules Committee, and they could rescind that. And that's what I'd like to do to this rule. It's on page 9 of the training, testing, and certification section in your booklet. Is there any discussion? Mark (Weber) do you have a problem with that?
- Mark Weber: No
- Meyer: Does it make sense? That enhanced skill would be deleted from the rules and we would not have a state mandated course for that. It would be included in the CPR training. Because CPR training is required for EMS providers.
- Larry Weber: It's also a paper thing. Physicians have to sign a physician preceptor form for all their folks and unless there are docs here that like signing stuff..
- Mark Weber: I make a motion to remove that.
- Ehlen: Second.
- Meyer: Moved and seconded. Is there any discussion? Any discussion? Any Discussion? All those in favor say Aye. Opposed same sign. Hearing none motion passes.

Motion unanimously passes by voice vote.

- Meyer: The next one is another scope enhancement called nitroglycerine administration. Again at some point there was a change in the EMT

curriculum to include nitro administration. This rule was put in before that was a part of the basic curriculum.

- Larry Weber: In the '94 curriculum it was put in as an assisted med. This was put in before we got to all of this, in order for those folks, based on physician preceptor, to actually carry in their rigs. The curriculum hasn't changed but the thought is it is still up to the medical director of every ambulance service to decide what he or she wants their personnel to do. And so that was the purpose. They're trained in pharmacology, there's no difference in that and assisting, it leaves the onus on the medical director.
- Meyer: This way they don't have to take a special course. Right now we require a special six hour course.
- Luithle: So they can carry the little nitro spray?
- Meyer: It is included in the primary training.
- Capes: It is covered in their basic refresher curriculum so it's not like they're not having it reviewed.
- Meyer: It is a redundant course. There may be more of those, but I didn't want to bite off more.
- Capes: I make a motion that we remove this course or rescind it.
- Meyer: Is there a second?
- Frame: Second.
- Meyer: Is there any discussion? Is there any discussion? Is there any discussion? All those in favor of removing nitroglycerine administration as a scope enhancement course please say aye. Opposed same sign. Motion carries.

Motion unanimously passes by voice vote.

Meyer asked the committee members to come up with meeting topics and submit them to the DEMS office when they could. Also, committee members should consider officers for election.

No other new business was offered. Meeting dates were discussed without finalization. Tentatively scheduled a March 18 meeting Meyer will be getting back to the committee for finalization. Tentatively the group will meet on a quarterly basis.

Meeting adjourned.